STATE OF MARYLAND
DEPARTMENT OF HEALTH & MENTAL HYGIENE

MEDICAL ASSISTANCE
PERSONAL CARE SERVICES PROGRAM

INCIDENT REPORT

Name of Recipient/M.A.#: _____ M.A.#_____

Name of Provider/Provider#:_____Provider#:_____

Where Did Incident Occur?_____
ADDRESS

_____
CITY COUNTY STATE ZIP CODE

Date of Incident: _____/_____/_____ Incident Reported to:_____

Time of Incident: _____ A.M.
_____ P.M.

Who Was Involved – Check All That Apply
- ☐ Provider
- ☐ Recipient
- ☐ Other _____

Witness (es):

_____
NAME ADDRESS PHONE

_____
NAME ADDRESS PHONE

Describe What Happened In Detail: (Use reverse side or additional sheet if necessary.)

_____

_____

_____

_____

Who Examined Individual After Incident?_____

Did Individual Receive Medical Treatment? ☐ Yes ☐ No

If Yes, Where Seen and Outcome of Visit: _____

_____

_____

Signature of Person Completing Form: _____

Date: _____ Phone: _____